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ABSTRACT

Twenty-six health manpower experts met to: (1) recommend criteria for selecting proposals for local/regional demonstration projects; (2) recommend criteria for selection of areas or sites in which to implement demonstration projects, and (3) develop guidelines for a national program to involve the health professions in alleviating the problem of maldistribution of health personnel. An introduction summarizes the purpose, objectives, composition, and meeting procedure of the task force. An extensive review of health manpower maldistribution, scarcity areas, and the results of efforts to correct maldistribution are reviewed in section 1, A Perspective of the Problem. Section 2, Guidelines for Local/Regional Demonsration Programs, describes the task force's proposed guidelines for projects; criteria for selection of sites; the role of interested community groups and the National Health Council (NHC) in planning demonstration projects; and discussions of modifying the selection and training of personnel to encourage service in scarcity areas and more effective utilization of existing manpower. Section 3, Recommendations for the Program at the National Level, explains the four types of roles suggested for the NHC by the task force. Appendixes on task force members, the agenda, participants, and public expectations of health delivery in scarcity areas conclude the document. (NH)

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REPORT ON DISCUSSIONS

OF THE TASK FORCE

ON THE MANPOWER DISTRIBUTION PROJECT

OF THE

NATIONAL HEALTH COUNCIL

January 24-26, 1973
Memphis, Tennessee

CE 002 812

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EXECUTIVE SUMMARY

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The National Health Council, under a contract with the Bureau of Health Manpower Education, Department of Health, Education and Welfare, sponsored a Task Force meeting of 26 health manpower experts in Memphis, Tennessee, on January 24-26, 1973 to (1) recommend criteria for selecting proposals for local/regional demonstration projects; (2) recommend criteria for selection of areas or sites in which to implement demonstration projects; and (3) develop guidelines for a national program to involve the health professions in alleviating the problem of maldistribution of health personnel. Pertinent conclusions on these issues are summarized below.

Local/Regional Demonstration Projects

The Task Force concluded that the design of demonstration projects should be left to the participating communities, but that the National Health Council should seek proposals from communities and local organizations that give emphasis to a variety of components. Wherever possible and when consistent with local requirements, the NHC should consider applying the following guidelines in selecting projects for support:

1. The inclusion of an educational component
2. The provision of economic incentives to health personnel
3. The utilization of team delivery models
4. The expansion of functions of existing health manpower
5. The inclusion of a management system for the project.

Suggested Criteria for Selecting Demonstration Sites

The Task Force suggested the following criteria for the selection of the demonstration sites: First priority should be given to communities that:

1. Are identified "scarcity" areas in accord with an accepted definition of scarcity.

2. Have taken the initiative in developing the project and give tangible evidence of a commitment to follow through. This commitment could be expressed in terms of financial support, endorsement of local officials, a past history of independent efforts at solving problems, or development of a plan to absorb administrative costs of the project when National Health Council funding must be discontinued.

3. Have attempted to inventory manpower resources, define community health manpower needs and desires, and assign priorities among them.

4. Have sponsors who are community based and include a substantial voice and representation from the people to be served.

The National Program

A range of activities was considered for inclusion within a national program that could be undertaken by the National Health Council on the problem of maldistribution of health manpower. It was proposed that the Council:

1. Promote acceptance of the concepts and principles embodied in demonstration projects and interpret these to member agencies. Since an innovative and otherwise distinctive approach is to be encouraged, support for these projects from the Councils' constituent membership is desirable.

2. Encourage efforts by National student health organizations to promote careers in scarcity areas. The NHC could encourage student organizations to undertake programs to give students contact with scarcity communities, sponsor inter-disciplinary program efforts and endorse student organizations' funding requests.

3. Function as a "clearing house" of information on efforts to bring health personnel to scarcity areas with particular attention to efforts aimed at encouraging recent graduates to practice in such areas.

4. Undertake a research program designed to identify the criteria and processes pertinent to the success or failure of projects and other efforts to recruit health professionals to scarcity areas.

* * *

INTRODUCTION

In mid 1972, the National Health Council received funding for a new manpower project which included the development of concepts to stimulate professional and voluntary health organizations and institutions in alleviating health manpower maldistribution. The terms of the contract required that the National Health Council

1. Orient professional organizations, university and college faculty, administrators and counsellors, state and metropolitan health careers executives, hospital and other health facility operators, student organizations and minority groups on

   - problems of health manpower maldistribution in specialty and geographic areas
   - methodologies for motivating students to select job locations in defined shortage areas
   - identified areas and problems of geographic maldistribution

2. Provide technical assistance in the development of programs and plans directed at stimulating the participation of the health and educational community to assist in alleviating the problem of geographic maldistribution.

To assist the National Health Council in the performance of the work required under the contract, a panel of approximately 25 experts in health manpower distribution was to be convened to review experiences with the problem to date and develop guidelines for National Health Council consideration for

- Planning a national program to involve health professions organizations, voluntary health agencies and state and metropolitan health careers councils in alleviating the problem;

- Recommending criteria to be used in selecting proposals for local or regional demonstration projects; and

- Recommending criteria for selecting a locality or localities to implement local/regional plans.

1. THE PURPOSE OF THE TASK FORCE MEETING

The Task Force meeting called by the National Health Council was held in Memphis, Tennessee on January 24, 25 and 26, 1973 and was conducted by Knight, Gladieux & Smith, Inc. of New York City, consultants employed for this purpose. The Conference was to focus upon developing ideas for solving rather than only redefining and discussing the problem. Therefore, extensive background material was assembled by National Health Council staff and sent to the Task Force members prior to the meeting. These data included (1) a restatement of the objectives of the Task Force meeting, (2) the planned methodology for conducting the meeting, (3) a working definition of health service scarcity areas, (4) a general summary of the advantages and disadvantages of practicing in rural and inner city shortage areas, and (5) a general review of specific incentive programs that have been tried and an assessment of their results.

These data were intended to provide all participants in the meeting with an identical frame of reference and to supplement the substantial information and knowledge each possessed.

2. THE CHARGE GIVEN THE TASK FORCE

The Task Force was requested to develop two sets of recommendations during the two and one-half day meeting.

(1) Recommendations for a national program to be conducted by the National Health Council staff to encourage students still in training to practice in geographic areas of need.

(2) Recommendations for a demonstration project(s) to alleviate health manpower maldistribution in rural and inner city areas. It was anticipated that these recommendations would

cover program concepts, criteria for the selection of demonstration areas and the nature of the organization(s) that should sponsor such projects. If possible, recommendations were to be made on specific scarcity areas in which demonstration projects could be undertaken.

Task Force recommendations were to be guidelines for consideration by the National Health Council on a national program that could be initiated by Council staff and on program specifications for a local demonstration project(s) for which proposals would be requested from appropriate groups and organizations.

3. THE COMPOSITION OF THE TASK FORCE

The guidance and advice of personnel with knowledge and expertise in health manpower distribution was a component of the National Health Council contract. A panel of approximately 25 experts on this subject, selected with the concurrence of the Bureau of Health Manpower Education project officer, was appointed.

People selected for the Task Force had a broad array of geographic and professional interests and concerns. They were selected for their expertise in health manpower distribution rather than for their representation of a categorical health interest. They were asked to express their own views on the problems and solutions and not function solely as spokesmen for official positions or views held by the organizations with which they were affiliated. (Appendix A following this report is a list of the Task Force members attending the meeting.)

4. THE MEETING PROCEDURE

Two issues had to be faced on the proceedings of the meeting -- the composition of the agenda and whether the Task Force should be sub-divided into smaller discussion groups.

(1) Organization of the Agenda

The primary concern in conference planning was to avoid an extended discussion of the problem without adequate attention to outlining solutions. As noted earlier, background

material on the problem was sent in advance to Task Force participants to give each a similar data base.

The agenda was designed to review briefly the problem and summarize rapidly the results to date of distribution projects. Two days were reserved for discussion of ideas for possible solutions, development of guidelines for national and local/regional demonstration projects and the identification of scarcity areas as potential demonstration sites. (Appendix C is the agenda used for the meeting.)

(2) Organization of Discussion Groups

The free exchange of views on potential national and local programs was a key objective of the meeting. The relatively large number of meeting participants (26) could have impeded such discussion. Consequently, contingency plans were made for dividing the group into smaller discussion groups if that was needed. The decision to proceed as a large group or as several smaller groups was to be made after the group had assembled and members had an opportunity to react with one another.

Following the scheduled presentations, Task Force participants indicated a desire to divide into two working groups. Accordingly, the Task Force was divided into two groups of 13 each with a discussion leader appointed from among the participants. The conference consultants, National Health Council staff and the Staff Advisory Committee selected the membership of each of the groups based upon the background and interests of the participants and their interaction. The objective was to create two groups with comparable professional and geographic backgrounds.

This report summarizes the discussions and the recommendations of the Task Force.

I. A PERSPECTIVE OF THE PROBLEM

A sweeping review of the problem of health manpower maldistribution was undertaken against a backdrop of expectations that people should have for their health services and health care. These discussions became the framework within which the Task Force considered the questions that had been placed before them.

At the outset, presentations were made to the Task Force on the problem of the maldistribution of health personnel and the results to date of corrective programs. The presentations stimulated a discussion of the expectations that people should have for the health delivery system. The presentations and subsequent discussions are summarized in this chapter.

Many Americans do not receive adequate health care because they live in areas without sufficient health personnel and facilities or because they are unable to gain access to existing resources. It is convenient but simplistic to view the problem only in terms of the geographic maldistribution of health resources, basically personnel, and to develop programs through which additional people can be located in scarcity areas. It is recognized, in some instances, that this could be a major part of the solution. However, Task Force discussions broadened the concept of scarcity in several important respects without losing sight of the original charge to the group or the idea that scarcity of service and scarcity of health personnel were closely related.

As with other resources, health personnel tend to concentrate in growing or fully developed geographic areas more likely to have the financial capacity to pay for health services. Conversely, health personnel, as people in other fields, are not attracted to and do not remain in areas that are economically depressed, geographically remote and sparsely populated. These areas are "scarcity" communities.

1. SCARCITY AREAS

Definitions of scarcity of health services are not uniform. However, a working definition of scarcity has been developed by the Health Services and Mental Health Administration, Department of Health,

Education and Welfare, which provided a framework for discussion of the concept of "scarcity". The definition states that scarcity of health services exists "when there is a quantitative lack of resources in a defined area and contiguous areas. If resources are adequate, the services may still be scarce because they are inaccessible to the target population. If resources and services are adequate and accessible, scarcity may still result from ineffective utilization of services." A discussion of these factors is presented below.

(1) Shortages of Health Personnel and Facilities

The absence of health personnel and facilities is one condition of scarcity. Included among these types of shortage circumstances are

- inadequate numbers of skilled human resources such as physicians, nurses, dentists and allied health personnel to meet needs.
- a shortage of hospitals, clinics, nursing homes and other health care facilities.
- the absence of health related services such as emergency care, dental, nutritional or mental health services.

(2) Inaccessibility of Health Services and Facilities

Inability of residents of an area to gain access to services and facilities also creates scarcity. Among the factors that impede access to services and facilities are

- absence of convenient public transportation and good roads.
- prohibitive transportation costs.
- exceptionally long travel times and distances.
- prohibitive costs of medical care that discourage those needing services from seeking them.
- complicated and confusing admissions and intake procedures that discourage people from seeking care.

- facilities that are not open during the hours when most persons in an area can seek medical attention.

(3) Ineffective Utilization of Health Services

Circumstances that lead to failure to use health service resources effectively also cause scarcity. Such circumstances include

- lack of coordination between existing services which may lead to inadequate referral procedures, duplicative services and lack of continuity of care.

- excessive costs that inhibit people from using available services may lead to their underutilization.

- lack of information and knowledge may result in people being uninformed about available services and facilities or about how to gain access to them.

- social and cultural attitudes of a population to be served may discourage utilization of health resources, especially if medical and dental care are seen as low priority items.

The Task Force did not accept this concept as the only valid definition of scarcity. Reservations were expressed over the manner in which the concept was being applied in "measuring the degree of scarcity" in communities. Concern was also expressed that data were being aggregated for excessively large geographic areas and therefore the data could not be sufficiently sensitive to significant disparities among segments of a population.

Despite the reservation about the applicability of this definition of scarcity, the Task Force recognized that the concept of scarcity is complex and that the addition of health services personnel and facilities into a scarcity area alone would not automatically improve the delivery of health care. Making personnel and facilities more readily available and assuring their effective utilization were considered equally important.

2. RESULTS OF EFFORTS TO CORRECT MALDISTRIBUTION

The results of a variety of incentive programs which have been implemented or proposed by various organizations to induce health care providers and persons in training to locate in scarcity areas were reviewed for the group. It was reported that various incentives have had limited success although in particular instances some have worked well. A discussion of some of the incentive programs and conclusions about their viability for long term solution of the problem that were presented to the group follows.

(1) Financial Incentives

Financial incentives generally have been given to medical students in the form of scholarships and tuition loans in return for service in a scarcity area for a period of time following graduation. These incentives were characterized as "weak means" to solve the problem since many students have elected to repay the loans and thereby rid themselves of the obligation.

It was reported, however, that in Canada some success has been achieved by guaranteeing specific levels of income to physicians if they agree to work in a scarcity area.

(2) Personal Contact/Community Promotion

Communities have attempted to attract health personnel, primarily physicians, by establishing personal contact with them and by promoting the community. Leading citizens in concert with health providers already in the area have been enlisted in such efforts. These efforts have included (1) using a professional public relations firm to conduct a community promotional campaign, and (2) offering a group practice rather than solo practice to new physicians interested in a rural or semi-rural setting and incorporating other disciplines such as nursing, x-ray and laboratory services so that young physicians can practice in the way they have been trained.

(3) Giving Students Exposure to Scarcity Areas During Training

It was reported that people tend to settle in an area with which they have had contact during their undergraduate, graduate school and post-graduate training. Therefore, it is thought that

acquainting students with the style of living in rural and semi-rural areas and exposing them to the health problems of such communities could persuade them to settle in these or similar areas upon graduation. Accordingly, educational programs have been developed in some states which offer students preceptorships in rural hospitals or the opportunity to study the basic health sciences in satellite schools throughout the state. It is anticipated that these programs will encourage some persons to practice in smaller communities as a result of this type of exposure.

(4) Recruitment of Personnel from Shortage Areas

Since people reared in shortage areas have had direct exposure to the problem, it is believed that those recruited for health careers from such areas will be more inclined to return to these same or similar locations to practice. Consequently, special efforts have been made to recruit people from shortage areas for health careers. Some graduates have been encouraged to practice in scarcity areas through these programs. Understandably, however, conclusions to date indicate that people recruited from scarcity areas are equally susceptible to the pressures that consistently have led health professionals to locate in geographic areas offering greater cultural and economic opportunities.

(5) Public Service to Fulfill Military Service Obligations

The National Health Service Corps is a federal program that offers health professionals the opportunity to serve for a two-year period in scarcity areas. The Corps, while relatively new, is serving about 150 communities at present. Despite some misgivings about the likelihood of being able to retain assigned individuals in the area once their two-year service expires, the National Health Service Corps device for placing personnel into an area was considered viable.

However, the long-term future of the Corps was considered wholly dependent upon the military draft since, for most, it is an alternative to military service. In the absence of positive inducements for service in the NHSC, it is likely that the discontinuance of the draft will reduce enrollment in the NHSC and cripple its capacity to serve.

(6) Other Incentives

In addition to these general activities, other suggestions that have been made in the past include training of enough additional numbers of health professionals to saturate areas to which they are ordinarily attracted so that outmigration of health professionals into scarcity areas results. In addition, job placement services are proving somewhat successful in several states. Tax incentives for practice in shortage areas have also been suggested as possible inducements to alleviate the problem.

It was reported to the group that despite the wide variety of programs and approaches taken to date, no one approach has been singularly successful and worthy of widespread replication.

II. GUIDELINES FOR LOCAL/REGIONAL DEMONSTRATION PROGRAMS

In addressing the question of local/regional demonstration programs to encourage additional numbers of new professionals into scarcity areas, the Task Force proposed criteria for (1) the type and range of activities that should be included within a demonstration program, (2) the communities that should be selected as demonstration sites, and (3) the role of interested community groups in planning the project. These criteria are presented in this chapter.

Task Force discussions on this subject covered a much broader range of issues, such as how the training of health care personnel could be modified to promote their service in scarcity areas and how the more effective use of existing personnel in a community can help alleviate the problem. Therefore, this chapter also summarizes the discussions on these subjects.

1. SUGGESTED GUIDELINES FOR THE DEMONSTRATION PROJECTS

The specific design of a demonstration project should be left to the community. It was suggested that the National Health Council seek to have a number of program activities included within a demonstration project and give greater consideration to proposals that include a larger array of these components. However, the Task Force clearly recognized that worthwhile projects that were responsive to the needs of some communities might not involve many of these components.

(1) Include an Educational Component in the Project

It was suggested that an educational component be made part of the project. Applications should, to the degree possible, draw upon the resources available at a convenient health science center or a medical, dental, nursing or other health-related educational institution in the immediate or surrounding area. Provisions should be made for continuing education in the project.

(2) Provide Economic Incentives

Demonstration projects should recognize that economic incentives play an important role in the way in which health manpower is distributed. If possible, demonstration projects should address the issue of the nature of economic incentives that will be made available to health personnel. Moreover, projects should not undertake steps that unduly restrict economic opportunities.

(3) Promote Better Utilization of Personnel Through the Team Delivery Model

Emphasis should be given to projects that will utilize the team approach to delivering care. In this manner, more effective utilization of manpower will result.

(4) Encourage Projects that Seek to Expand the Functions of Existing Manpower

The Task Force concluded that ineffective use was being made of available manpower in many areas because artificial barriers confined the range of duties that those trained people were permitted to assume. Projects should be encouraged that demonstrate how to lower these barriers and broaden the contribution that the health occupations can make to the delivery system.

(5) Require the Inclusion of a Management System for the Project

Demonstration projects should be well managed if their prospects of success are to be strengthened. Therefore, demonstration proposals should include a management plan. The elements of the plan should cover systems for program planning, organization, operations and program evaluation. Particular emphasis was placed upon the need for program evaluation since the objective is to identify activities that could be replicated elsewhere.

In addition to suggesting the above-indicated guidelines, Task Force members noted that attention will be needed to assure that health care initiated through demonstration projects meets generally accepted criteria. Suggestions were also offered, therefore, that in both selecting and monitoring projects, appropriate attention be given

- that the health care provided meets professional standards and does not represent "second class" treatment.

- that a full range of health care services is extended to all residents in the demonstration area and that provision is made for prevention and health education programs.

- that arrangements are provided for maintaining continuity of contact with patients, so that although individual staff members might change, the institutional memory of the patient, his medical history and his health status is maintained.

2. SUGGESTED CRITERIA FOR SELECTING DEMONSTRATION SITES

A large number of communities are likely to wish to apply as demonstration sites. The Task Force concluded that within limits the demonstration communities should

(1) be identified scarcity areas in accord with an accepted definition of "scarcity".

(2) have taken the initiative in developing the project and give tangible evidence of a commitment to follow through. This commitment could be expressed in terms of financial support, the endorsement of local officials, a past history of independent efforts at solving the problem, or development of a plan to absorb the administrative costs of the demonstration project at some point in the future when National Health Council funding must be discontinued.

(3) have expressed initiative through inventorying resources, obtaining clear definition of community health manpower needs and desires, and assigning priorities among these.

(4) have program sponsors who are community based and include a substantial voice and representation of the people to be served.

There may be areas or sites where it would be desirable to do demonstration projects which do not meet these recommended criteria. The Task Force believed that these areas should be given separate and special consideration.

3. SUGGESTED COMMUNITY ROLE IN PLANNING THE DEMONSTRATION PROJECT

Despite general agreement that the approaches taken to date have achieved occasional success, either independently or in combination with each other, the Task Force concluded that no one approach to encouraging personnel into scarcity areas was so successful that it deserved greater priority than others. In fact, it was suggested that emphasis should be given to encouraging new innovative approaches in demonstration projects that do not resemble efforts to date. The group also concluded that the scarcity community should determine for itself whether to undertake a demonstration project and decide upon the nature of the activities.

It was difficult for the Task Force to predict the type of projects that communities were likely to propose, but it was expected that they could range from activities as broad as providing personnel to build a "system" in an area now without services to simply providing staff to help man existing facilities and strengthen program services. The Task Force agreed that depending upon the nature of the activity encompassed in the project, efforts should be made to involve a number of community interests in the planning process. Therefore, it was suggested that there be several requirements for the process by which the demonstration projects are planned.

(1) Provide Local Providers a Voice in the Development of the Project

The cooperation and support of local providers and their organizations were considered essential to the success of a demonstration project. Therefore, local providers should be consulted and participate in the development of the project plans.

(2) Give People to be Served by the Project a Role in Project Planning

Just as the provider should be included within deliberations on the proposed project, the Task Force also believed that the

people to be served by the project should also participate in the planning. Participation should include an opportunity to express their health needs and wants, to specify the services they wish to receive, to express the way in which they wish to be treated and to assist in organizing and managing the project.

(3) Do not Impose a Project upon a Community

Since local support was considered an essential ingredient to the success of any project, the Task Force insisted that no attempt be made to induce a community to sponsor a demonstration program if local interest and support were not present. No success was thought possible in a community that neither wanted a project nor felt one was needed.

(4) Encourage Communities to Develop Projects that are Tailored to their Particular Needs and Desires

The Task Force was not concered if a wide variety of approaches to the problem were taken by the communities wishing to sponsor demonstration projects. In fact, differences and creative approaches should be encouraged.

The Task Force believed it was more important that communities be given an equal opportunity to exercise a choice, rather than having identical projects throughout the country.

4. THE NHC ROLE IN THE DEMONSTRATION PROJECTS

In developing the various criteria discussed previously, the Task Force also discussed the role the NHC could play in promoting the local/regional demonstration projects. It was suggested that the NHC

(1) Promote and Publicize the Criteria for Demonstration Projects

The range of activities that the NHC staff should consider undertaking includes publicizing the criteria, promoting the proposed project before appropriate health professions organizations and requesting proposals to be submitted. Assistance to groups in preparing proposals for submission was also recommended.

(2) Select and Assist Demonstration Projects

The NHC should use appropriate screening and selection techniques in choosing the demonstration projects. Assistance should be provided, as appropriate, to the selected groups in getting their projects under way.

(3) Work With the Demonstration Projects

It was also suggested that the NHC staff be prepared to work with demonstration projects as they proceed. This might include providing technical assistance, undertaking project evaluation and assisting in preparing required reports.

5. DISCUSSION ON MODIFYING THE SELECTION AND TRAINING OF HEALTH PERSONNEL TO ENCOURAGE SERVICE IN SCARCITY AREAS

As noted previously, Task Force discussions covered the point that personnel should be encouraged during their training to locate in scarcity areas rather than after their training is completed and they are established elsewhere. The Task Force believed that current practices in selecting and training health care personnel do not do as much as possible to reinforce or stimulate a student's interest and desire to serve in a scarcity area. Therefore, the Task Force proposed that the National Health Council suggest and support several modifications in the selection and training of health care personnel. These suggestions included

(1) Support the Use of Modified Criteria for Selecting Persons for Training

Task Force participants were not fully satisfied that criteria used for selecting persons for training in the health field enhances the prospects of their locating in scarcity areas. It was suggested that insufficient weight and attention have been given to the motivation of students in considering their credentials for entry into training. The National Health Council should support making admission procedures more sensitive to the interests of prospective students in practicing in scarcity areas. The Council should also support efforts to admit a number of them into training even if their credentials, while meeting requirements, may not be as strong as other applicants.

(2) Reinforce Students' Desires to Serve People that Initially Attracted them to Health Service Careers

It was stated that many students entering medical school want to become family practitioners. However, relatively few of these same people are still so inclined at the end of their training. It was suggested that students are heavily exposed to influences during training that encourage specialization or research and consequently career objectives change. Moreover, frequently a prolonged period of time elapses between the point when students begin training and the period when they can assist in serving people. As a result, students who are motivated toward service may find that during this extended period, the intensity of their desire to serve may be blunted and other career interests and patterns develop. The same illustration applies to other health professions.

It was suggested that the National Health Council support the concept of providing students with field and clinical experience to alert them to the needs for service in scarcity areas. In addition, greater sensitivity to the influences during training that prompt people to specialize would be helpful so that counter influences could be instituted, i.e., periodic exposure to practitioners, training in scarcity areas, and having practitioners directly involved in training.

(3) Emphasize and Support the Concept of the Team Approach During the Training Period

The team approach to delivering health care was considered essential to service in scarcity areas. Therefore, training in the team approach and inter-disciplinary education were urged to prepare individuals for this type of working pattern.

(4) Support the Development of Community Based Training Programs in Scarcity Areas

People living within a scarcity area are a resource for developing support personnel and could be developed as such. It was proposed that training programs could be assembled for a scarcity area through which residents could receive training in health care occupations. The National Health Council could help support the development of such training

programs. The point was made that the programs should be conducted without major investments in capital facilities. The program should be time limited and be terminated once an adequate number of people in the area have been trained. Mobile training facilities that could then be moved to another scarcity area would be particularly useful in conducting such training programs.

(5) Support the Involvement of Practitioners and the Community in the Training Programs

Concern was expressed that too much training takes place without sufficient exposure to practitioners and the community. Discussion was focused on whether the educational system alone should be responsible for the training of health providers.

As noted earlier, it was suggested that training should take place with community resources, that opportunity be given to students for community exposure during training and that practitioners be involved in their training.

6. MORE EFFECTIVE UTILIZATION OF EXISTING MANPOWER

The Task Force discussions considered the ways in which existing personnel could be used more effectively. The following approaches were discussed.

(1) Expansion of the Functions of Health Personnel Already in the Area

Professional and legal barriers frequently restrict too narrowly the role that health personnel could play in the health delivery system. Consequently, "shortages" exist even where there is a quantitative adequacy of personnel in an area.

The Task Force discussed the desirability of expanding the roles and responsibilities of health personnel in an area to capitalize upon the investment in their education and training. They believed that all health manpower should be utilized to the fullest extent of their capabilities.

(2) Encouragement and Promotion of Continuing Education

The acquisition and expansion of knowledge and skills of health providers should be undertaken through programs of continuing education. The Task Force discussed the desirability of promoting the use of existing personnel through encouraging and promoting continuing education among health personnel already in a scarcity area.

Task Force members also cited a number of additional elements which they felt contributed to "scarcity" in many areas. These points are included as Appendix D.

III. RECOMMENDATIONS FOR THE PROGRAM AT THE NATIONAL LEVEL

The National Health Council's broad membership and national visibility were considered assets that could be exploited successfully in designing a national program. Several types of roles for the National Health Council were suggested by the Task Force.

1. PROMOTE ACCEPTANCE OF THE LOCAL/REGIONAL DEMONSTRATION PROJECT CONCEPTS

The Council should be prepared to promote acceptance by its constituent agencies of the principles embodied in regional or local demonstration projects and to interpret and actively promote these principles with member bodies. This proposal recognizes that probability that demonstration projects will involve innovative or otherwise distinctive processes and that a positive interpretive effort will be required to gain support for them from the Council's constituent membership. Activities that the NHC staff could undertake in support of this effort include news releases, reports to and appearances before NHC member associations explaining the demonstration projects and publicizing the projects in national publications.

2. ENCOURAGE STUDENT HEALTH ORGANIZATIONS TO PROMOTE CAREERS IN SCARCITY AREAS TO THEIR MEMBERS

The Council should endeavor to develop and expand efforts by national student health organizations to encourage members to start their careers in scarcity areas. The role of the NHC to this end might include: encouragement of student organizations to undertake continuing programs to give interested students direct contact with scarcity communities; sponsorship of inter-disciplinary program efforts; and endorsement of student organization funding requests to foundations and governmental sources. The NHC staff could undertake several types of activities in support of this program. Included among them could be regional conferences in which service in scarcity areas is discussed with students, faculty and practitioners working

with students in clinical settings; staff promotion of scarcity area service before student groups and professional organizations; and publicizing the effort being made to attract young health professionals into scarcity areas.

3. FUNCTION AS A "CLEARING HOUSE" OF INFORMATION ON EFFORTS TO BRING HEALTH PERSONNEL TO SCARCITY AREAS

The Council should develop an internal capability to function as a national "clearing house" for providing information on past and present efforts to bring health personnel to scarcity areas with special focus on efforts to encourage recent graduates to practice in such areas. The collection of data from private and public agencies that collect information on such projects and the distribution of news on important developments in the field were seen as a role the NHC staff could play.

4. SEEK SUPPORT FOR RESEARCH INTO THE SUCCESS AND FAILURE OF PROGRAMS TO RECRUIT PERSONNEL FOR SERVICE IN SCARCITY AREAS

The Council should seek funding to support a research program conducted by persons skilled in social, economic and organizational research designed to identify the criteria and processes pertinent to the success or failure of projects and other efforts intended to recruit health professionals to scarcity areas.

With regard to the latter two proposals, it was observed during Task Force discussions that relatively little information of a factual nature is known about many past or present health manpower distribution projects, that misconceptions exist and that as a result, failures are often recommended for replication elsewhere.

The Task Force also recommended that the National Health Council adopt an advocacy role in extending manpower services into scarcity areas. For example, the Task Force believed that the Council should study, take public positions on, and urge its membership to work to remove undue restrictions imposed by: jurisdictional barriers; reciprocity limitations; licensure requirements; prohibitions to the expansion of services; and State and local laws which

inhibit the extension of available health services to scarcity areas and to individuals in need of improved health care.

TASK FORCE MEMBERSHIP

NHC MANPOWER DISTRIBUTION PROJECT

Alonzo Atencio, Ph. D.
Assistant Dean of Student Affairs
School of Medicine
University of New Mexico
Albuquerque, New Mexico

Robin F. Badgley, Ph. D.
Chairman
Department of Behavioural Science
University of Toronto
Toronto, Ontario, Canada

Alberta Barnes
Program Director
"Breakthrough to Nursing"
National Student Nurses' Association
New York, New York

James Earl Bates, D. P. M.
President
Pennsylvania College of Podiatric Medicine
Philadelphia, Pennsylvania
(Co-chairman, Steering Committee, American
Podiatry Association Manpower Study)

David O. Born, Ph. D.
Coordinator and Associate Professor
Dental Information Service Center
School of Dentistry
University of Minnesota
Minneapolis, Minnesota

Elsa L. Brown, R. N.
Dean, Allied Health
Medical College of Ohio at Toledo
Toledo, Ohio

Kevin P. Bunnell, Ph. D.
Director, Division of General Regional Programs
Western Interstate Commission for Higher Education
Boulder, Colorado

Viron Diefenbach, D. D. S.
Assistant Executive Director
Dental Health
American Dental Association
Chicago, Illinois

Clifton O. Dummett, D. D. S.
Associate Dean, Extramural Affairs
Chairman, Department of Community Dentistry
School of Dentistry
University of Southern California
Los Angeles, California

C. Emil Fasser, R. P. A.
Coordinator
Physician's Assistant Program
Veterans Administration Hospital
Baylor College of Medicine
Houston, Texas

Spencer Guimarin
Director
Texas Health Careers Program
Austin, Texas

Kenneth C. Hager
Executive Director
Oklahoma Council for Health Careers
Oklahoma City, Oklahoma

Joseph Hamburg, M. D.
Dean, College of Allied Health Professions
Albert B. Chandler Medical Center
University of Kentucky
Lexington, Kentucky

Hugh Hemsley, M. D.
Bethune Medical Center
Compton, California
(member, Board of Directors, School of
Medicine, Drew University)

Elizabeth E. Kerr, R.N.
Director, Program in Health Occupations Education
Division of Health Affairs
University of Iowa
Iowa City, Iowa

Cynthia R. Kinsella, R.N., Ed.D.
Consultant
Seal Cove, Maine
(formerly Director of Nursing, Mt. Sinai Hospital, New York City)

Marland Koomsa
Chief, Health Education Branch
Indian Health Service
Health Services and Mental Health Administration
Department of HEW
Rockville, Maryland

Arch Lugenbeel
Health Manpower Specialist
Office of the Governor
Division of Administration
State of South Carolina
Columbia, South Carolina

Alberta W. Parker, M.D.
Clinical Professor of Community Health
School of Public Health
University of California, Berkeley
Berkeley, California

Beth Pearl, R.N.
Keam's Canyon, Arizona
(Public Health Nurse practicing on Indian reservation; formerly president, National Student Nurses' Association)

Henry B. Peters, O.D.
Dean, School of Optometry
The Medical Center
University of Alabama
Birmingham, Alabama

Christopher A. Rodowskas, Jr., Ph.D., R.Ph.
Director, Pharmacy Manpower Information Project
American Association of Colleges of Pharmacy
Silver Spring, Maryland

Janice B. Sarama (student in Pharmacy)
School of Pharmacy
Duquesne University
Pittsburgh, Pennsylvania

Vernon C. Smith, Jr., M.D.
Chairman, Board of Directors
Student National Medical Association
Washington, D.C.

Leopold J. Snyder, M.D.
Fresno, California
(Chairman, AMA Council on Rural Health)

Fred J. Struve, Jr.
Director of Governmental Relations
American Society for Medical Technology
Houston, Texas

APPENDIX B(1)

OTHERS PARTICIPATING IN TASK FORCE MEETING

I. Staff Advisory Committee, Manpower Distribution Project

Herbert K. Gatzke, Director
Bureau of Manpower and Education
American Hospital Association

Nicholas M. Griffin, Director
Department of Health Manpower
American Medical Association

Jean Harris, M.D.
Executive Director
National Medical Association Foundation

Judy Jaffee, Education Specialist
Manpower Development and Training
Office of Education
Department of Health, Education and Welfare

William M. Samuels
Executive Director
Association of Schools of Allied Health Professions

Daniel R. Smith, Chief
Manpower Initiatives Program
Bureau of Health Manpower Education
National Institutes of Health
(Project Officer for NHC Manpower Distribution Project)

II. National Health Council Staff

Peter G. Meek, Executive Director

Levitte Mendel, Associate Director

Mrs. Anne R. Warner, Program and Communications Director,
Manpower Distribution Project

Ellen Sax, Research and Information Coordinator,
Manpower Distribution Project

Mrs. Harriet Tiebel, Health Careers Field Consultant

III. Knight, Gladieux & Smith, Inc. (management consulting firm contracted to conduct Task Force meeting)

Gerald R. Riso, Managing Director

Edwin C. Foster, Principal

IV. Resource Persons and Observers

Douglas A. Fenderson, Ph. D.
Director, Office of Special Programs
Division of Allied Health Manpower
Bureau of Health Manpower Education
National Institutes of Health

Royal A. Crystal
Assistant Director for Evaluation, Evaluation Branch,
Division of Health Care Services
Community Health Service
Health Services and Mental Health Administration

William Christoffel, Ph. D.
Acting Director
Office of Program Planning and Evaluation
National Health Service Corps
Health Services and Mental Health Administration

Alexander Adler
Associate Director, Office of Information
Bureau of Health Manpower Education
National Institutes of Health

V. Recorders (senior students, College of Medicine, University of Tennessee)

Jeff Lichtenstein
Frank Messineo
Michael McCarthy

AGENDA

NATIONAL HEALTH COUNCIL TASK FORCE MEETING

January 24-26, 1973
Sheraton Peabody Hotel, Memphis, Tennessee

I. January 24, Wednesday

A. Registration (noon-2:00 P. M.)
- Parlor A, Mezzanine

B. Afternoon Orientation Session (2:00 P. M. to 5:00 P. M.)
- Room 214, Mezzanine

1. Welcome and Introduction (Dr. Joseph Hamburg, Task Force Chairman)

2. Role of the National Health Council (Mr. Peter Meek, NHC)

3. Summary of Task Force Objectives and Introduction of Participants (Mrs. Anne Warner, NHC)

4. Outline of Meeting Procedure (Mr. Gerald Riso, Knight, Gladieux & Smith)

5. Presentations by Resource Consultants

a. Major problems of health manpower maldistribution (Dr. Douglas A. Fenderson, NIH)

b. Health manpower scarcity areas and their characteristics (Mr. Royal A. Crystal, HSMHA)

6. Questions, Summation and Review

C. Reception and Cocktails (6:30 P. M.
- Room 200

II. January 25, Thursday

A. General Morning Meeting (9:00 A.M. to 10:00 A.M.)
- Forest Room, Mezzanine

1. Brief Restatement of Problems and Meeting Objectives

2. Organization of Discussions. (The group may be divided into two sections for discussion purposes or may stay in a single body.)

B. Morning Discussion Meeting(s) (10:15 A.M. to 12:15 P.M.)
- Room 214 and Forest Room

1. Exploration of

a. The most appropriate involvement for health related professional organizations, voluntary health agencies, and state and metropolitan health career councils in conducting demonstration projects.

b. Realistic roles of educational institutions, the community and local, regional and health agencies in encouraging students to pursue careers in geographic health scarcity areas.

2. Discussion of

a. Program/Project Objectives

b. Criteria for selecting demonstration site(s)

c. Objectives in organizing and managing programs/projects

d. Objectives of a national program complementary to demonstration projects

C. Recess for Lunch (12:15 P.M. to 2:15 P.M.)

D. Afternoon Group Meeting(s) (2:15 P. M. to 5:30 P. M.)
- Continuation of Morning Discussion Topics

E. Recess for Dinner (5:30 P. M. to 8:00 P. M.)
(Special arrangements have been made for conference participants to dine at the Petroleum Club in the Hotel if they wish)

F. General Evening Meeting (8:00 P. M. to 10:00 P. M.)

1. Summarization of Discussion Conclusions

2. Discussion on Conclusions and Preliminary Agreement On:

a. The role of health agencies and organizations in persuading student career decisions about practicing in scarcity areas.

b. Geographic areas in which scarcity problems exist.

c. Criteria for the selection of demonstration project(s).

d. Objectives and expectations for demonstration project(s).

e. Initial identification of geographic areas where experimental incentive projects could most appropriately be implemented.

III. January 26, Friday

A. General Morning Meeting (8:30 A. M. to 1:00 P. M. with a half hour break at 10:30 for coffee or cokes)

1. Summary of Previous Day Consensus on Shortage Areas, Barriers to Corrective Action, Incentives and Criteria for Demonstration Project Selection.

2. Discussion and General Agreement on Guidelines and Methodology for Programs to be Carried Out in the Above Regional Experimental Projects.

3. Discussion and General Agreement on a Complementary Program Which the National Health Council can Implement at the National Level.

4. Summary of Task Force Conclusions and Recommendations (Mr. Riso and Mr. Edwin Foster, Knight, Gladieux & Smith).

5. Review of Follow-up Processes (Mrs. Warner).

6. Appreciation and Adjournment (Dr. Hamburg).

DISCUSSION OF PUBLIC EXPECTATIONS OF HEALTH DELIVERY IN SCARCITY AREAS

In considering the National Health Council project for encouraging new health professionals into scarcity areas, the Task Force also discussed the broader issue of providing additional and improved health care to residents and their expectations for health care as a background for their deliberations. In discussing this broader issue, two important points were covered.

- objectives for delivering health care should be defined in more specific terms.
- health should not be looked upon in a vacuum; consideration of the community and national environment in which services are being provided is also necessary.

(1) Objectives for the Health Delivery System

The Task Force discussed the point that the provision of health care should be related to the issues of access to care, and the quality, continuity and efficiency of the delivery system. These objectives should shape programs and projects for delivering health care into scarcity areas. The general conclusions for providing health services in scarcity areas are summarized below.

- Providing Accessibility to Health Care

  Accessibility to health care has several dimensions.

  - Personal Accessibility. All individuals should have access to the delivery system.
  - Comprehensive Services. A broad range of services should be provided, including preventive services and health education.
  - Comprehensive Coverage. All persons in an area should be encompassed by the delivery system.

- Quantitative Adequacy. There should be sufficient health service resources available to provide the services and coverage required by the community.

. Providing "Quality Care"

Quality was "defined" in terms of both the provider and recipient of health care.

- Professional Standards of Care. Health care should be provided in accordance with standards of quality developed by professionals and administered through mechanisms developed and operated by professionals and their professional organizations.

- Personal Acceptability. The manner in which health care is provided should respect the dignity and self-esteem of the recipient and be sensitive to cultural and ethnic considerations.

. Establishing Continuity of Care

Continuity of health care was considered from two viewpoints.

- Personal Centered Care. The person requiring treatment should be the focal point of the system, as contrasted to emphasis upon the treatment of specific ailments on a crisis intervention basis.

- Linkages. Movement through various levels of care as needed should be facilitated through appropriate linkages among providers and various facilities.

. Achieving System Efficiency

Efficient operation of the system was considered to have three aspects.

- System Adequacy. The resources needed to provide coverage and services should be available.

- Equity. The system should respond in the same way to all persons.

- Cost Effective. The system should be organized and managed to achieve maximum effective use of all available resources.

In summary, these points were made during the background discussion preceding consideration of the issue of the geographic maldistribution of personnel and the development of criteria for projects to encourage new personnel into shortage areas.

(2) Viewing Health Within National Health Policy and the Local Environment

The Task Force also discussed the point that health should not be looked upon in a vacuum. National health policy and goals for the availability of broader-based financing mechanisms and financial coverage of health services such as outreach, health education, prevention and health counselling will help to shape the structure and operation of the delivery system.

Public policy on the nature and type of health programs that will be funded, the conditions placed upon the use of such funds and the administrative mechanisms through which the funds are expended also will substantially effect the way in which the delivery system can respond to the service needs of the community environment into which the delivery system must be placed. The delivery system will be affected by all of these circumstances and it is unrealistic to ignore them in setting objectives for the delivery system.

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